

# DISCRETIONARY ENTRANT APPLICATION FOR COVER.

## A TO BE READ AND COMPLETED BY THE EMPLOYER/SENIOR PARTNER

### Please complete in BLOCK CAPITALS

We'll need this form to be completed if you're including a late or early entrant whose required cover is less than the policy free limit. If you're unsure if the employee, partner or LLP member is an early or late entrant you'll find more details on the latest evidence of insurability statement that we've sent you for each policy. Cover will not be provided until we've advised you in writing of any terms that may apply and, where appropriate, you have accepted those terms.

If the cover required is above the free limit we'll need a member's declaration form to be completed instead. We'll also need a member's declaration to be completed if 'yes' is answered to any of the questions on Section B.

To help the employee, partner or LLP member complete the member's declaration we can arrange for a nurse to contact them. The nurse is from a company called Medicals Direct, who work on our behalf, and they will carry out a tele-interview to complete the member's declaration over the phone. Alternatively if they prefer to complete the form themselves you'll be able to find this on our website <http://www.legalandgeneral.com/workplacebenefits> under protection documents or you can ask us for a copy. Please state on the form that they are an early or late entrant.

If Critical Illness cover is being requested, please ensure that you have provided the employee, partner or LLP member with details regarding the operation of pre-existing and related conditions exclusions.

Name of Employer/firm

Group policy no(s).

## DETAILS OF EMPLOYEE/PARTNER/LLP MEMBER

Where the information being given for question 1.3 is not the same for all policy types, separate entries are required.

### 1.1 What is your full name?

Surname

Forename(s)

Mr/Mrs/Miss/Ms/Other

### 1.2 Occupation

(please describe fully)

### 1.3 Scheme earnings

(if applicable)

Membership category

(where policy has more than one)

**DETAILS OF EMPLOYEE/PARTNER/LLP MEMBER – continued**

**1.4** Please tick against the required benefit type and state the benefit formula.

Life Assurance	<input type="checkbox"/>	<input type="text"/>
Dependants' Pension	<input type="checkbox"/>	<input type="text"/>
Group Income Protection	<input type="checkbox"/>	<input type="text"/>
Group Critical Illness Cover	<input type="checkbox"/>	<input type="text"/>

Cover will be provided under the policy(ies) requested as soon as Legal & General has advised terms in writing and, where applicable, those terms have been accepted. If you wish cover to start from a later date please insert later date here

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

**1.5** Please tell us the reason for discretionary entry. e.g. early and late entrant (see technical guide) or deferred retiree

**B TO BE READ AND COMPLETED BY THE EMPLOYEE/PARTNER/LLP MEMBER**

**2.1** What is your date of birth?

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

**2.2** Marital status (e.g. single, married, registered civil partner, divorced, widowed)

**DECLARATION BY EMPLOYEE**

The information provided on this application for cover is only used by Legal & General to assess the cover being requested and any future cover. For confidentiality you have the right to send the form, when it's been completed, in a sealed envelope directly to the chief medical officer at Group Protection, Medical Underwriting Team, Legal & General Assurance Society Limited, Legal & General House, St. Monica's Road, Kingswood, Tadworth, KT20 6EU.

**Please answer all the questions carefully and honestly, as an incorrect answer could result in a claim not being paid. You must not amend the declarations below.**

	YES	NO
1. Have you ever had:		
• Any form of cancer, heart attack, angina, heart disease (including valvular disease) or stroke?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been diagnosed as having:		
• Motor neurone disease, Alzheimer's or Huntington's disease, muscular dystrophy, cirrhosis of the liver, cystic fibrosis, multiple sclerosis, diabetes, HIV/Aids, Hepatitis B or C, dementia, cerebral palsy, Parkinson's, chronic obstructive pulmonary disease, emphysema or any mental health related illness – including stress, depression, anxiety, bipolar, psychosis?	<input type="checkbox"/>	<input type="checkbox"/>
3. In the last six months have you consulted a doctor or healthcare professional because of:		
• Raised blood pressure or cholesterol, an irregular or abnormal heart beat, chest pain, dizziness, loss of consciousness or shortness of breath, a blood disorder, alcohol related illness, digestive related symptoms, kidney or bladder disorders (isolated urinary tract infection may be ignored), any disorder of the eyes or ears, arthritis, spine, neck, shoulder, knee or joint disorder – including slipped disc, sciatica, carpal tunnel syndrome or RSI (repetitive strain injury)?	<input type="checkbox"/>	<input type="checkbox"/>
4. In the last four weeks have you had any of the following signs or symptoms of illness for which you have consulted a doctor or have an appointment to see a doctor for:		
• fatigue that has restricted normal activity for over 10 days not known to be caused by a minor condition such as flu?	<input type="checkbox"/>	<input type="checkbox"/>
• numbness or dizziness lasting more than a day not known to be caused by a minor injury or a minor condition such as an ear infection?	<input type="checkbox"/>	<input type="checkbox"/>
• a new mole or other growth on the skin or an existing one that has become itchy or painful or has changed its shape, size or colour?	<input type="checkbox"/>	<input type="checkbox"/>

If you've answered 'No' to all four questions above please go to Section D.

If you've answered 'Yes' to any of the four questions we'll need further medical evidence which could involve a medical examination and blood or other tests.

You'll need to complete a member's declaration form. We can arrange a nurse to contact you from Medicals Direct, who work on our behalf. They will carry out a tele-interview and complete the form over the phone. Please complete your contact details in Section C.

If you prefer you can complete the form yourself. You'll find this on our website: [www.legalandgeneral.com/workplacebenefits](http://www.legalandgeneral.com/workplacebenefits) under protection documents or you can ask us for a copy.

**C****CONTACT DETAILS FOR TELE-INTERVIEW**

If you have answered 'Yes' to any of the questions in Section B please complete your contact details below.

Address

Email address

Contact number(s)

Mobile	<input type="text"/>	Preferred number (please tick)	<input type="checkbox"/>
Home	<input type="text"/>		<input type="checkbox"/>
Work	<input type="text"/>		<input type="checkbox"/>

Please tell us a time that would be convenient for Medicals Direct to contact you to complete the telephone interview.

You will be asked questions on your health, lifestyle, family history, travel, occupation and hazardous pursuits. The duration of the interview can vary so please allow at least 30 minutes.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
08.30 – 11.45	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.00 – 15.00	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15.15 – 17.45	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18.00 – 20.45	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

**D****DECLARATION FOR CRITICAL ILLNESS COVER**

Please only complete this section if you are applying for Critical Illness cover.

- Are your children (if any) or, if they are eligible for cover, your spouse or registered civil partner in a poor state of health and intend to see a doctor about any health, medical or psychiatric condition in the foreseeable future?
- Are you aware or do you suspect that your children (if any) or, if they are eligible for cover, your spouse or registered civil partner are suffering from any condition that might lead to a claim under the Group Critical Illness Cover policy?

YES NO

<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

If you have answered 'Yes' to either of the above two questions, please say why below.

Date of birth of spouse or registered civil partner  
(where to be insured)

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

**Use of personal information:** Legal & General takes client privacy very seriously. I understand that Legal & General will use the personal information collected via this application and any other information that I provide to Legal & General ("my information") for the purposes of:

1. Providing me with Legal & General products and services and dealing with my enquiries and requests;
2. Underwriting and administering the policy(ies) including processing claims;
3. Carrying out market research, statistical analysis and client profiling.

I understand that given the global nature of Legal & General's business, it may be necessary to transfer my information to countries outside the European Economic Area in order to provide Legal & General's services to me.

**Disclosures:** I understand that Legal & General will disclose my information to other companies within the Legal & General group of companies, regulatory bodies, law enforcement agencies, future owners of Legal & General's business, suppliers engaged by Legal & General to process data on its behalf and when necessary, to a reinsurer.

**Access:** I understand that I have the right to ask for a copy of my information in return for payment of a small fee. To obtain a copy of your information please write to Legal & General at:

Group Information Protection, Legal & General Assurance Society Limited, Legal & General House, Kingswood, Tadworth, Surrey KT20 6EU.

#### Employee/Partner/LLP member's - declaration and consent

Signature:

Date:

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

Name in  
BLOCK CAPITALS:

**Sensitive data:** I consent to Legal & General using the medical and health information provided in this application, and any other medical information provided in the course of this application, solely for the purposes of allowing Legal & General to underwrite and administer the policy(ies) and/or any subsequent policy and in connection with any claim.

**I agree in the event of a claim, Legal & General may obtain medical and health information where necessary (which may include genetic information) from any doctor who at any time has attended me concerning anything which affects my physical or mental health, and authorise the giving of such information.**

My medical information (and other information collected via this application) may be disclosed to Legal & General's reinsurer and to any doctor that Legal & General uses, including my own GP, and to any other insurance company I apply to for products or services.

I understand that a copy of the completed application is available on request.

By signing this form:

- I agree to the use of my information as set out above.
- I declare that to the best of my knowledge and belief, the statements in this application are true and complete. I understand that any false declaration may result in the rejection of a subsequent claim.
- I agree that a copy of this application shall have the validity of the original.

## CONTACT US

**0845 072 0753** We may record and monitor calls. Call charges will vary.

groupprotection.medicalunderwriting@landg.com  
legalandgeneral.com/workplacebenefits

**Group Protection – Medical Underwriting Team, Legal & General Assurance Society Limited**  
Legal & General House, St Monica's Road, Kingswood, Tadworth, Surrey KT20 6EU

**Legal & General Assurance Society Limited**  
Registered in England No. 166055  
**Registered office:** One Coleman Street, London EC2R 5AA

We are members of the Association of British Insurers.

W1783 01/12 NONGASD